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No. 97-1402

In the Supreme Court of the United States

OCTOBER TERM, 1997

UNIVERSITY HEALTH SERVICES, INC., PETITIONER

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether the court of appeals correctly upheld the determination of the Secretary of Health and Human Services that petitioner was not entitled to reimbursement, for fiscal year 1986, for uncollected hospital charges incurred by patients to whom petitioner provided Medicare services.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-19a) is reported at 120 F.3d 1145. The order (Pet. App. 20a-39a) and judgment (Pet. App. 40a) of the district court are unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 83a) was entered on August 28, 1997. A petition for rehearing was denied on November 26, 1997. Pet. App. 82a. The petition for a writ of certiorari was filed on February 24, 1998. This Court's jurisdiction is invoked under 28 U.S.C. 1254(1).

STATEMENT

This case arises under Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*, better known as the Medicare Act. Petitioner, University Health Services, Inc., brought this action in federal district court, seeking judicial review of the final decision of the Secretary of Health and Human Services disallowing petitioner's claim of entitlement to $524,807 in reimbursements for uncollected hospital charges incurred by patients to whom petitioner provided Medicare services. Pet. App. 20a, 33a.

1. Medicare is a program of health insurance providing medical benefits primarily to elderly and disabled persons. 42 U.S.C. 1395c. Medicare beneficiaries are entitled to have payments made on their behalf for certain inpatient and outpatient hospital care and related services provided by a hospital or "provider." 42 U.S.C. 1395d, 1395x(u); 42 C.F.R. 400.202. Providers participate in the Medicare program by entering into a "provider agreement" with the Secretary. 42 U.S.C. 1395cc. The Secretary reimburses providers through "fiscal intermediaries," generally private insurance companies, which are responsible for determining the total amount of program reimbursement due a provider each year in accordance with Medicare policy. 42 U.S.C. 1395g, 1395h(c)(1). The Medicare program, however, does not pay 100% of covered health care services. Medicare patients remain responsible for paying various deductibles and coinsurance amounts. 42 U.S.C. 1395e.

When Medicare patients fail to make the payments for which they are responsible, the Medicare program reimburses hospital providers based upon the

statutory "reasonable cost" standard.[1] 42 U.S.C. 1395x(v) (1)(A). "Reasonable cost" is defined in the Medicare Act as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services" to beneficiaries. *Ibid.* The Act directs the Secretary to promulgate regulations "establishing the method or methods to be used" to determine "reasonable costs." *Ibid.* In prescribing such regulations, the Secretary is required to ensure that provider reimbursement is related to beneficiary care, so that the "necessary costs of efficiently delivering covered services to [Medicare beneficiaries] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [the Medicare program]." 42 U.S.C. 1395x(v)(1)(A)(i). That provision prohibits shifting the costs of Medicare services to non-beneficiaries and *vice versa*.

Pursuant to this grant of authority, the Secretary promulgated regulations establishing principles of "reasonable cost reimbursement." 42 C.F.R. Pt. 413. Medicare reimbursement regulations generally treat uncollectible hospital charges ("bad debts") as deductions from revenue that are not actual costs incurred in the delivery of medical services. 42

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[1] For cost reporting periods beginning October 1, 1983, reimbursement for inpatient hospital operating costs is made under the Prospective Payment System. Under that system, a hospital is paid a standardized payment rate for each discharge, based on the diagnostic classification assigned to that discharge. 42 U.S.C. 1395ww(d); 42 C.F.R. 412.1 *et seq.* Certain other costs, including the uncollected Medicare deductible and coinsurance amounts at issue in this case, continue to be reimbursed separately.

C.F.R. 413.80(a) and (c). A different rule applies to uncollectible charges to Medicare beneficiaries for deductibles and coinsurance amounts, because the "failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries." 42 C.F.R. 413.80(d). Thus, consistent with the Medicare Act's prohibition against shifting the costs of Medicare services to non-beneficiaries, the regulations provide that "the costs attributable to the deductible and coinsurance amounts that remain unpaid [by Medicare beneficiaries] are added to the Medicare share of allowable costs." *Ibid.*; see also 42 U.S.C. 1395x(v)(1)(A)(i).

To be an allowable cost, a Medicare bad debt must satisfy the following criteria:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

42 C.F.R. 413.80(e).

To assist intermediaries and providers in applying these and other reimbursement principles to specific cases, the Secretary has issued an extensive, detailed

set of interpretive rules in the form of guidelines, manuals, letters, and other publications, including the Provider Reimbursement Manual (PRM). See *Shalala* v. *Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995) (the PRM is a "prototypical example" of a set of interpretive rules "issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers") (quoting *Chrysler Corp.* v. *Brown*, 441 U.S. 281, 302 & n.31 (1979)). With respect to the collection of bad Medicare debts, the PRM states: "[t]o be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts for non-Medicare patients." Pet. App. 3a (quoting PRM § 310). Section 310 of the PRM further provides:

> A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency.

Ibid.

Because the actual costs of services cannot be determined until the end of a given cost year, providers receive estimated payments at least monthly during the cost year, with subsequent adjustments for any underpayment or overpayment. 42 U.S.C. 1395g, 1395x(v)(1)(A)(ii); 42 C.F.R. 413.64(b) and (f). The intermediary determines the provider's total reimbursable reasonable costs for services, based upon an annual cost report submitted by the provider. 42 C.F.R. 405.1803. The provider is notified of the intermediary's determination in a written Notice of Program Reimbursement. *Ibid.*

If the provider is dissatisfied with the intermediary's reimbursement determination, the amount in controversy is $10,000 or more, and other procedural requirements are satisfied, the provider may appeal that determination to the Provider Reimbursement Review Board (PRRB). 42 U.S.C. 1395*oo*(a); 42 C.F.R. 405.1835(a), 405.1841(a). The decision of the PRRB is final unless the Secretary, on her own motion, reverses, affirms, or modifies the Board's decision. 42 U.S.C. 1395*oo*(f)(1). The Secretary has delegated her review authority to the Administrator of the Health Care Financing Administration (HCFA), whose decision on review constitutes the final decision of the Secretary. 42 C.F.R. 405.1875. A provider may thereafter seek judicial review of the agency's final decision in district court, in accordance with the provisions of the Administrative Procedure Act, 5 U.S.C. 701-706. See 42 U.S.C. 1395*oo*(f)(1); 42 C.F.R. 405.1877.

2. In 1987, Congress placed a moratorium on the Secretary's authority to change Medicare bad debt

reimbursement policy that was in effect on August 1, 1987. Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203, § 4008(c), 101 Stat. 1330-55 (reprinted, as amended, in 42 U.S.C. 1395f note). In its current form, the moratorium provides:

> CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.—In making payments to hospitals under [the Medicare program], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under [the Medicare program] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under [the Medicare program] (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency). The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

3. Petitioner, a non-profit hospital in Augusta, Georgia, is an authorized Medicare provider. Pet. App. 5a. It is undisputed that, for the 1986 Medicare cost reporting period, petitioner stopped collection efforts on all of its Medicare accounts (*i.e.*, debts relating to Medicare patients' deductibles and coinsurance amounts) on which there had been no activity for 120 days, wrote them off as bad debts for accounting purposes, and sought $524,807 in reimbursement from Medicare. *Ibid.* Petitioner also wrote off as bad debts its non-Medicare accounts that were delinquent 120 days, but it then transferred those accounts to an in-house collection agency for further collection efforts. *Id.* at 5a, 21a. Petitioner claimed to have followed the same debt collection practice in previous years. *Id.* at 5a, 21a-22a.

Petitioner received reimbursement of its Medicare bad debt claims for each of the years prior to 1986. Pet. App. 5a, 21a-23a. In each of those years, petitioner's Medicare bad debt claims were allowed by its fiscal intermediary, Blue Cross and Blue Shield of Georgia, but without examination of petitioner's underlying collection practices. *Id.* at 5a, 10a-11a, 14a. With respect to petitioner's 1986 cost year, the intermediary conducted a full audit focusing specifically on petitioner's bad debt practices. *Id.* at 5a, 22a-23a. The intermediary determined that petitioner's bad debt collection practices were inconsistent with Medicare policy (PRM § 310), because petitioner failed to refer Medicare accounts to its in-house collection agency after the first 120 days, even though it did refer non-Medicare accounts; therefore, the intermediary disallowed petitioner's request for reimbursement for its 1986 bad debt claims. *Id.* at 5a.

Petitioner sought administrative review of the intermediary's decision. The PRRB found that petitioner had demonstrated that sound business judgment justified petitioner's dissimilar treatment of Medicare and non-Medicare accounts. In support of that conclusion, the PRRB noted that petitioner had shown financial losses in connection with collection efforts in the 1989-1991 cost years, during which petitioner complied with the intermediary's directive to refer all accounts, both Medicare and non-Medicare, to its in-house collection agency. Pet. App. 5a-6a.

The Secretary reversed the PRRB, concluding that petitioner had failed to show that it had engaged in reasonable collection efforts with respect to its Medicare accounts. The Secretary determined that petitioner's bad debt collection method was inconsistent with the plain language of the PRM, which directed providers to treat the collection of Medicare and non-Medicare accounts similarly. The Secretary also determined that petitioner had failed to show that sound business judgment justified its decision not to refer Medicare accounts to its collection agency. Finally, because petitioner had not acted in compliance with the pertinent Medicare regulations in 1986, the Secretary ruled that the OBRA moratorium did not bar the intermediary's disallowance of reimbursement costs for that cost year. Pet. App. 6a.

4. Petitioner filed the present action in the United States District Court for the Southern District of Georgia, seeking review of the Secretary's disallowance of reimbursement. The district court reversed the Secretary and entered summary judgment in favor of petitioner. The court found that petitioner used the same debt collection practices

in 1986 that it had used in earlier years in which the intermediary had allowed reimbursement of petitioner's bad debt claims. The court further held that the Secretary had tacitly ratified petitioner's collection efforts through the acts of her intermediary and that, consequently, her decision with respect to the 1986 cost year was a change in policy that had an unfair retroactive effect. The court therefore concluded that the Secretary was equitably estopped from disallowing reimbursement for 1986. Finally, and in the alternative, the court found that the OBRA moratorium barred the Secretary from denying petitioner's claim for bad debt reimbursement. Pet. App. 6a-7a; see generally *id.* at 24a-39a.

5. The court of appeals reversed and reinstated the Secretary's disallowance. Pet. App. 1a-19a. The court determined that the Secretary's decision was neither arbitrary nor inconsistent with the governing Medicare policies, rules, and guidelines. The court ruled that PRM § 310 "ensure[s] that a provider treat similarly those accounts for which the provider has no guarantor as those for which the government acts as guarantor." Pet. App. 10a. Thus, "[c]ompliance with this policy presumably prevents Medicare from being used as a payor for unpaid bills that might yet be paid by the responsible party." *Ibid.* That requirement, the court held, was not "arbitrary, plainly erroneous, or inconsistent with Medicare policy." *Ibid.*

The court of appeals rejected petitioner's suggestion that, because the intermediary had allowed prior claims for reimbursement, the Secretary's disallowance amounted to retroactive rulemaking. The court determined that the guidelines had been consistent all along and that it was the intermediary's failure

to audit prior claims that led to the prior allowances. Pet. App. 10a-11a. "[T]here [wa]s no allegation or indication that Blue Cross had been supplied with the necessary information to discover [petitioner's] practices prior to the audit." *Ibid.* The court, agreeing with the Secretary, also rejected petitioner's argument that it had sound business reasons for justifying noncompliance with the Secretary's similar-treatment policy. The court determined that substantial evidence supported the Secretary's determination in this regard. *Id.* at 12a-14a.

Finally, the court ruled that the OBRA moratorium did not bar the Secretary's disallowance. The court agreed with the Secretary that the OBRA moratorium was not triggered under the facts of this case for two interrelated reasons: all of the intermediary's allowances prior to 1986 were based on submissions from petitioner without any audit focusing on petitioner's underlying collection practices; and, when the intermediary conducted a full audit of petitioner's collection practices with respect to the 1986 cost year, the intermediary discovered for the first time the illegality of petitioner's collection practices. In short, the court agreed with the Secretary that payment of prior bad debt claims, in the absence of an audit that focuses specifically on the provider's practices, is not acceptance of the provider's debt collection practices or establishment of a policy that would trump the Secretary's policies. Pet. App. 14a-18a.

The court below agreed with the analysis of the OBRA moratorium in the Eighth Circuit's decision in *Hennepin County Medical Center* v. *Shalala*, 81 F.3d 743 (1996), which emphasized that the intermediary's audit had provided the acceptance of the

provider's bad debt practices. Pet. App. 17a. The court also noted that the Fifth Circuit's decision in *Harris County Hospital District* v. *Shalala*, 64 F.3d 220 (1995), was "factually distinguishable from * * * the instant case" because in that case the intermediary's payment of the provider's claim for reimbursement of bad debt followed an investigation and audit which, in the Fifth Circuit's view, constituted "acceptance" for purposes of triggering the OBRA moratorium. Pet. App. 17a n.5.[2]

ARGUMENT

The decision of the court of appeals is correct, and further review by this Court is unwarranted.

1. Petitioner contends that it is entitled under the OBRA moratorium to reimbursement for the bad debts at issue, because a fiscal intermediary had "accepted" petitioner's debt collection policy by allowing petitioner's claims for reimbursement for such debts. The court of appeals properly rejected that contention.

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[2] In the court of appeals, the Secretary also contended that the OBRA moratorium precludes the Secretary from requiring a change in a debt collection policy accepted by a fiscal intermediary only if the accepted debt collection policy relates to "criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an *external* collection agency." 42 U.S.C. 1395f note (Continuation of Bad Debt Recognition for Hospital Services) (emphasis added). Because the policy at issue in the present case involved petitioner's failure to refer Medicare claims to an *in-house* collection agency, the Secretary argued, acceptance of that policy could not have triggered the OBRA moratorium. Because it ruled for the Secretary on other grounds, the court of appeals did not reach that alternative argument. Pet. App. 15a.

Because the phrase "accepted such [bad debt collection] policy" is not defined in the OBRA moratorium, its meaning must be ascertained through consideration of the structure of the Medicare program and the legislative history of the OBRA moratorium. See *Hennepin County Med. Ctr.* v. *Shalala*, 81 F.3d 743, 749 (8th Cir. 1996). As the court of appeals correctly concluded (Pet. App. 16a), such consideration leads to the conclusion that a fiscal intermediary does not necessarily accept a bad debt collection policy simply by allowing a claim for reimbursement of bad debts. To the contrary, an intermediary's prior allowance of a particular claim for reimbursement is not an acceptance of the provider's general debt collection practices if, as in the present case, "the intermediary conducts a full audit and discovers new, previously unavailable information indicating that the provider's practices were not consistent with Medicare rules and guidelines in existence prior to August 1, 1987." Pet. App. 18a. In such circumstances, "the moratorium is not triggered and retroactive disallowance may be appropriate." *Ibid.*

That conclusion is supported by the long-standing regulation permitting the Secretary to disallow bad debt payments already made to a provider, by reopening the notice of program reimbursement within three years. See 42 C.F.R. 405.1885. As the court of appeals explained, "[i]f issuance of a notice of program reimbursement were invariably an acceptance . . . the reopening regulation * * * would be superfluous. This would frustrate the intent of Congress that existing regulations be enforced." Pet. App. 16a (quoting *Hennepin County*, 81 F.3d at 749).

The legislative history of the OBRA moratorium also supports the conclusion that a fiscal intermediary's allowance of reimbursement is not necessarily an acceptance of a bad debt collection policy. The Conference Report on the 1988 amendment to the OBRA moratorium suggests that Congress never intended that an intermediary's decision to allow reimbursement, without more, would preclude the Secretary from later disallowing such reimbursement:

> Congress intended that the actions of fiscal intermediaries occurring prior to August 1, 1987 to approve *explicitly* hospital[s'] bad debt collection practices, to the extent such action by the fiscal intermediary was consistent with the regulations, PRRB decisions, or program manuals and issuances, are to be considered an integral part of the policy in effect on that date, and thus not subject to change.

H.R. Conf. Rep. No. 1104, 100th Cong., 2d Sess. 277 (1988) (emphasis added). See also *ibid.* ("the conferees do not intend to preclude the Secretary from disallowing bad debt payments based on regulations, PRRB decisions, manuals and issuance[s] in effect prior to August 1, 1987").[3]

Thus, the structure of the Medicare program and the legislative history of the OBRA moratorium

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[3] At the time of the 1988 amendment to the OBRA moratorium, Congress had not yet added the language expressly referring to acceptance of debt collection policies by fiscal intermediaries. That language was added in 1989, in a retroactive amendment enacted to "clarif[y]" Congress's intent in enacting the OBRA moratorium. See H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. 737 (1989).

support the common-sense conclusion of the court of appeals that a fiscal intermediary does not accept a Medicare provider's debt collection policy simply by reimbursing the provider for bad debts. Rather, such reimbursement can properly be regarded as an acceptance of the provider's debt collection policy only if, at a minimum, the fiscal intermediary can be charged with knowledge of the debt collection policy it is supposed to have accepted. The record in the present case, however, indicates that the intermediary's decisions to reimburse petitioner's bad debt claims prior to 1986 were made without knowledge of the challenged debt collection practice, which was discovered only as the result of a full audit conducted after the reimbursement decisions had been made. See Pet. App. 10a-11a ("there is no allegation or indication that Blue Cross [the fiscal intermediary] had been supplied with the necessary information to discover [petitioner's] practices prior to the audit"). The court of appeals therefore properly rejected petitioner's claim that his debt collection policy had been accepted by a fiscal intermediary within the meaning of the OBRA moratorium. See also *Hennepin County*, 81 F.3d at 749-750 (fiscal intermediary's reimbursement of bad debt claim would not amount to acceptance of provider's debt collection policy if subsequent audit revealed new and material information); cf. *Harris County Hosp. Dist.* v. *Shalala*, 64 F.3d 220, 222 (5th Cir. 1995) ("We hold that [the fiscal intermediary's] previous repayment of the Hospital's claim for reimbursement of bad debts *after an investigation and audit* constitutes acceptance under OBRA.") (emphasis added).[4]

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[4] Relying on *Harris County*, petitioner contends (Pet. 19

2. Even if a fiscal intermediary has accepted a provider's debt collection policy, the OBRA moratorium is not triggered unless that acceptance is "in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency." 42 U.S.C. 1395f note (Continuation of Bad Debt Recognition for Hospital Services). Petitioner contends that the court of appeals in this case incorrectly held that, for that requirement to be met, "the provider's bad debt collection practices must have been consistent with Medicare rules existing in 1987 [as presently interpreted by the Secretary]."

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n.5) that a fiscal intermediary can be found to have accepted a debt collection policy even though the intermediary lacked specific knowledge of the policy. As the court of appeals in the present case noted, however, it is not at all clear that *Harris County* supports such a contention. See Pet. App. 17a n.5. In any event, *Harris County* is "factually distinguishable" from the present case. *Ibid.* The fiscal intermediary in *Harris County* had conducted an investigation and audit before providing the reimbursement that was claimed to have constituted acceptance of the provider's debt-collection policy, 64 F.3d at 222, and there was no suggestion in the opinion of the court of appeals in *Harris County* that the fiscal intermediary subsequently discovered new, material evidence. Pet. App. 17a n.5. In the present case, by contrast, it was only after the fiscal intermediary conducted a full audit of petitioner's 1986 claims that the intermediary discovered new, material evidence demonstrating that petitioner's debt collection practices were inconsistent with the Secretary's policies. See 42 C.F.R. 405.1885 (permitting reopening after allowance within three years if new and material evidence is discovered). Thus, *Harris County* is consistent with the holding of the court of appeals in the present case that the fiscal intermediary had not accepted petitioner's bad debt collection policy.

Pet. 14 (quoting Pet. App. 16a) (bracketed material inserted by petitioner). Petitioner further contends (Pet. 13-22) that that holding conflicts with *Hennepin County*, 81 F.3d at 751, and *Harris County*, 64 F.3d at 223 n.11, both of which hold that the provider's debt collection practices need not be consistent with the Secretary's current interpretation of the Medicare rules existing in 1987, and that it is sufficient that the provider's debt collection practices reflect a reasonable interpretation of the Medicare rules existing in 1987. Petitioner's arguments do not warrant further review.

a. Petitioner has not accurately characterized the holding of the court of appeals in the present case. In the passage upon which petitioner relies, the court of appeals indicated that it was adopting the approach taken by the Eighth Circuit in *Hennepin County*. See Pet. App. 17a ("We find the reasoning advanced by the Eighth Circuit in Hennepin to be persuasive and, therefore, adopt it."). It would therefore be surprising if there were a conflict between the two courts on the point. In fact, the court of appeals in the present case did not state that the current interpretation of the Secretary, rather than the reasonable understanding of the intermediary or provider, must be considered when determining whether an accepted policy was consistent with the Medicare rules in existence in 1987. To the contrary, the language of the court's decision, though not free from ambiguity, suggests that the court did not view the Secretary as free to apply a new interpretation to the Medicare rules in existence in 1987. Pet. App. 17a ("Congress * * * sought to freeze a moment in time, forbidding the Secretary to change the criteria after that date, but allowing full enforcement of the policies before

it."). Thus, the ruling of the court of appeals turns not on the adoption of a rule of law inconsistent with the holding of *Hennepin County*, but rather on the conclusion that the Secretary was not applying a new interpretation in this case. *Id.* at 18a ("We reject [petitioner's argument] that the Secretary's disallowance of its Medicare bad debt claim constitutes either a new substantive rule or a stiffer application of a pre-existing rule.").[5]

b. In any event, the present case would not be an appropriate vehicle in which to address any disagreement that might exist as to the question of when an intermediary's acceptance of a provider's debt collection practices is "in accordance with the rules

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[5] Petitioner contends (Pet. 16-18) that a footnote in the decision of the court of appeals conflicts with a footnote in *Hennepin County*. That contention does not merit this Court's review. In the present case, the court of appeals rejected petitioner's reliance on two decisions of the PRRB finding that providers had sound business reasons justifying dissimilar treatment of Medicare and non-Medicare bad debt claims. Pet. App. 13a n.4 ("these decisions constitute specific applications of the relevant regulations and guidelines and, therefore, do not dictate a given result in light of the specific circumstances presented here"). According to petitioner, *Hennepin County* reached a contrary conclusion, holding that the same two PRRB decisions invariably preclude the Secretary from denying reimbursement based on a provider's decision to refer only non-Medicare bad debts to a collection agency. Pet. 16-18 (citing *Hennepin County*, 81 F.3d at 751 n.7). It is not at all clear that the court in *Hennepin County* intended to definitively resolve that question in the case before it, much less to state a broad legal rule applicable to all bad debt claims involving referral of claims to collection agencies. See 81 F.3d at 751 n.7 ("Any failure of [the provider] to use collection agencies *should not* therefore affect the final result *in this case*.") (emphasis added).

in effect as of August 1, 1987." 42 U.S.C. 1395f note (Continuation of Bad Debt Recognition for Hospital Services). The court of appeals in this case properly concluded that the fiscal intermediary had not accepted petitioner's debt collection policy. See pp. 12-15, *supra*. Petitioner therefore would not be entitled to relief even if he could prevail on his further contention that a fiscal intermediary's acceptance of a debt collection practice suffices to trigger the OBRA moratorium so long as the accepted policy is in accord with a reasonable understanding of the Medicare rules in effect in 1987. Further review of that claim is therefore not warranted.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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